



# Influenza Consent Form

This voucher permits the individual named below to receive influenza vaccine

**BRING THIS VOUCHER WITH YOU**

**STAFF USE ONLY**

Cash/Credit/Check # \_\_\_\_\_

Contract Pay: \_\_\_\_\_

Insurance: \_\_\_\_\_

KanCare Title 19:  Title 21:

**Thomas County Health Department**

350 S. Range, Suite #2

Colby, KS 67701

Phone: 785.460.4596

Fax: 785.460.4595

Visit our website at: [www.thomascohealth.com](http://www.thomascohealth.com)

Find us on Facebook: [@thomascountyhealthdept](https://www.facebook.com/thomascountyhealthdept)

**Vaccine: Seasonal Influenza**

Demographic Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: M or F

Health History Information (Please check answer)

- 1. Has this person had a serious reaction to vaccine in the past? Yes No
  - 1a. Person had cardiac arrest, collapsed or called 911 after getting vaccine? Yes No
- 2. Does this person have an allergy to eggs or egg products? Yes No
  - 2a. Has this person had a reaction to eggs involving symptoms other than hives, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or another emergency medical intervention? Yes No
- 3. Has this person ever had Guillain-Barre Syndrome (GBS)? Yes No
  - 3a. Person had a history of GBS within six weeks after having flu vaccination? Yes No
- 4. Is this Person allergic to Thimerosal or mercury products? Yes No
  - 4a. Person experienced respiratory distress or collapsed using Thimerosal products? Yes No
- 5. Is this Person currently having any signs or symptoms of COVID-19? Yes No
  - 5b. Has this person been advised by a healthcare provider that you are a suspect case of COVID-19, regardless of signs or symptoms? Yes No

I, the undersigned, certify that all the above information is correct to the best of my knowledge. I hereby authorize the recipient of this document to share this information with public health entities at the local, state and federal level for purposes of ensuring medication efficacy and safety. I have been offered a Notice of Thomas County Health Department Privacy Practices.

Client Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

**Clinician Use Only:**

Vaccine Provided: IM

Location: R L Deltoid VL

Clinic Site: \_\_\_\_\_

Vaccinator's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

LOT NUMBERS:

Private:

VFC:

High Dose: UT7715AA

Vaccine Information Statements

VIS Date: 08/06/2021

WebIZ: \_\_\_\_\_ Scanned: \_\_\_\_\_ Billed: \_\_\_\_\_